MercyKids

Patient History Form

Patient Name: _____ DOB: _____

Do you see any doctors outside of Mercy? Yes No Where? _____

Preferred pharmacy name & phone number: _____

Reason for visit today:_____

Child History

Does your child have any allergies? Yes No If yes, please specify: _____

Are your child's Immunizations up to date? Yes No

Has your child ever had surgery? Yes No If yes, please specify:_____

_____

Any reactions to anesthesia? Yes No

What medications has your child tried (please include dosage)?

Axid _____ Nexium _____ Prilosec_____ Prevacid _____

Zantac _____ Kristolose_____ Pepcid _____ Miralax _____

Review of Systems (please check all that apply):

Gastrointestinal	Cardiovascular	Respiratory
O Diarrhea	O Hypertension	O Asthma
O Constipation	O Hypotension	O Chronic Cough
O Heartburn	O Irregular Heartbeat	O Hoarseness
O Trouble Swallowing	O Chest Pain	O Pneumonia
O Nausea / Vomiting	O Other _____	O Tracheotomy
O Abdominal Pain		
O Other _____	O Fatigue	O Fever
Genitourinary	**Endocrine**	**Neurological**
O Kidney Disease	O Diabetes	O Seizures
O Frequent UTI's	O Thyroid Disorders	O Migraines/Headaches
O Other _____	O Other _____	O Stroke
Ear, Nose, Throat	**Musculoskeletal**	**Integumentary**
O Chronic Ear Infections	O Pain	O Rash
O Sore Throat / Strep /Mono	O Stiffness	O Lesions
O Nosebleeds	O Joint Swelling	O Wounds
O Other _____	O Other _____	O Other _____

Illnesses or Medical Conditions (immediate family only):

			Family Member (Relationship to patient)
Colon/Rectal cancer	Yes	No	
Stomach problem	Yes	No	
Anesthesia reaction	Yes	No	
Colon polyps	Yes	No	
Ulcerative colitis	Yes	No	
Crohn's disease	Yes	No	
Celiac disease	Yes	No	
Arthritis	Yes	No	

Please list any prescription or over-the-counter medications your child is currently taking:

_____

_____